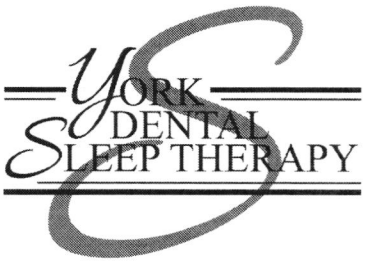

Medical History

Name:_____ DOB:_____

Address:_____

Phone number:_____ Email:_____

Medical Insurance:_____

Family Doctor:_____ Last visit within 6mos? Y N

Why are you seeing us today?_____

_____

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you smoke or use tobacco?	Height:
For Office Use Only			
BP		Heart Rate:	Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Actonel/Boniva/Fosamax
☐	☐	Alcohol/Drug Abuse
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Bones/Joints/Valves
☐	☐	Asthma
☐	☐	Autoimmune Issues
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Dye/SLS Sensitivity
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Food Allergies
☐	☐	Frequent Headaches
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur

Y	N	Conditions
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Herpes/Fever Blisters
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Hospitalized For Any Reason
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Osteoporosis
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sinus Problems
☐	☐	Sleep Apnea
☐	☐	Snoring

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

YORK DENTAL SLEEP THERAPY

Gordon M. Bell, DDS, FICOI, FAGD
DABDSM, DABCDSM, DACSDD

STOP BANG

Screening for: Obstructive Sleep Apnea

Name: _____

STOP

S (snore)	Have you been told that you snore?	Yes	No
T (tired)	Are you often tired during the day?	Yes	No
O (obstruction)	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	Yes	No
P (pressure)	Do you have high blood pressure or on medication to control high blood pressure?	Yes	No

If you answered YES to two or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea. It is recommended that you contact your primary care provider to discuss a possible sleep disorder.

To find out if you are at moderate to severe risk of Obstructive Sleep Apnea, complete BANG questions below.

B (BMI)	Is your body mass index greater than 28?	Yes	No
A (age)	Are you 50 years old or older?	Yes	No
N (neck)	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	Yes	No
G (gender)	Are you a male?	Yes	No
	Are you aware of clenching and grinding?	**YES**	**NO**

The more questions you answer YES to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea.